

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034991

Facility Name: PARK HOUSE

Address: 2320 SOUTH LAWNDALE CHICAGO 60623
Number City Zip Code

County: COOK

Telephone Number: (847) 647-1717 Fax # (847) 647-0222

IDPA ID Number: 36-3620976

Date of Initial License for Current Owners: 01/01/89

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PARK HOUSE

0034991 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>14</u>	Skilled (SNF)	<u>14</u>	<u>5,110</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>92</u>	Intermediate (ICF)	<u>92</u>	<u>33,580</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,690</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,587</u>	<u>2,587</u>	8
9	SNF/PED					9
10	ICF	<u>30,793</u>	<u>1,056</u>		<u>31,849</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,793</u>	<u>1,056</u>	<u>2,587</u>	<u>34,436</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.00%

D. How many bed-hold days during this year were paid by Public Aid?

1,099 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started

01/01/89

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date

01/01/89

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

_____ and days of care provided

2,587

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

12/31/2002

Fiscal Year:

12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **PARK HOUSE** # **0034991** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	146,788	13,245	12,969	173,002		173,002	(321)	172,681			1
2	Food Purchase		122,338		122,338	(11,717)	110,621	(429)	110,192			2
3	Housekeeping	114,608	15,882		130,490		130,490		130,490			3
4	Laundry	28,744	45,559		74,303		74,303		74,303			4
5	Heat and Other Utilities			67,236	67,236		67,236	291	67,527			5
6	Maintenance	11,049	25,413	25,781	62,243		62,243	8,759	71,002			6
7	Other (specify):*			12,065	12,065		12,065		12,065			7
8	TOTAL General Services	301,189	222,437	118,051	641,677	(11,717)	629,960	8,300	638,260			8
	B. Health Care and Programs											
9	Medical Director			2,500	2,500		2,500		2,500			9
10	Nursing and Medical Records	817,152	36,376	253,563	1,107,091		1,107,091	(227,479)	879,612			10
10a	Therapy	50,961	5,029	40,698	96,688		96,688	(34,530)	62,158			10a
11	Activities	53,715	6,572	2,057	62,344		62,344		62,344			11
12	Social Services	22,670		3,735	26,405		26,405		26,405			12
13	Nurse Aide Training											13
14	Program Transportation			586	586		586		586			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	944,498	47,977	303,139	1,295,614		1,295,614	(262,009)	1,033,605			16
	C. General Administration											
17	Administrative	104,089		219,600	323,689		323,689	(182,484)	141,205			17
18	Directors Fees											18
19	Professional Services			262,631	262,631		262,631	(212,770)	49,861			19
20	Dues, Fees, Subscriptions & Promotions			32,790	32,790		32,790	(5,478)	27,312			20
21	Clerical & General Office Expenses	95,356	9,669	102,682	207,707		207,707	(21,285)	186,422			21
22	Employee Benefits & Payroll Taxes			237,873	237,873	11,717	249,590		249,590			22
23	Inservice Training & Education			1,165	1,165		1,165	703	1,868			23
24	Travel and Seminar							282	282			24
25	Other Admin. Staff Transportation			1,615	1,615		1,615	1,985	3,600			25
26	Insurance-Prop.Liab.Malpractice			38,048	38,048		38,048	2,987	41,035			26
27	Other (specify):*							27,585	27,585			27
28	TOTAL General Administration	199,445	9,669	896,404	1,105,518	11,717	1,117,235	(388,475)	728,760			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,445,132	280,083	1,317,594	3,042,809		3,042,809	(642,184)	2,400,625			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			39,006	39,006		39,006	40,097	79,103			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							259,516	259,516			32
33	Real Estate Taxes			74,824	74,824		74,824		74,824			33
34	Rent-Facility & Grounds			369,401	369,401		369,401	(363,484)	5,917			34
35	Rent-Equipment & Vehicles			21,457	21,457		21,457	(2,851)	18,606			35
36	Other (specify):*											36
37	TOTAL Ownership			504,688	504,688		504,688	(66,722)	437,966			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,618	133,208	175,826		175,826	(131,422)	44,404			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		42,618	191,243	233,861		233,861	(131,422)	102,439			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,445,132	322,701	2,013,525	3,781,358		3,781,358	(840,328)	2,941,030			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,754)	30		9
10	Interest and Other Investment Income	(33,576)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(429)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(15,312)	21		18
19	Entertainment		20		19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(2,777)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,033)	20		28
29	Other-Attach Schedule	932			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,349)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(771,979)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (771,979)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (840,328)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 932	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	932		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **PARK HOUSE**# **0034991**

Report Period Beginning:

01/01/2002

Ending:

12/31/2002**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(6,000)	5,679	0	0	0	0	0	0	0	0	(321)	1
2	Food Purchase	(429)	0	0	0	0	0	0	0	0	0	0	(429)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	291	0	0	0	0	0	0	0	0	291	5
6	Maintenance	932	0	7,827	0	0	0	0	0	0	0	0	8,759	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	503	(6,000)	13,797	0	0	0	0	0	0	0	0	8,300	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(250,000)	22,521	0	0	0	0	0	0	0	0	(227,479)	10
10a	Therapy	0	(40,697)	6,167	0	0	0	0	0	0	0	0	(34,530)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(290,697)	28,688	0	0	0	0	0	0	0	0	(262,009)	16
	C. General Administration													
17	Administrative	0	(219,600)	37,116	0	0	0	0	0	0	0	0	(182,484)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(218,000)	5,230	0	0	0	0	0	0	0	0	(212,770)	19
20	Fees, Subscriptions & Promotions	(7,210)	0	1,732	0	0	0	0	0	0	0	0	(5,478)	20
21	Clerical & General Office Expenses	(15,312)	(63,600)	57,627	0	0	0	0	0	0	0	0	(21,285)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	703	0	0	0	0	0	0	0	0	703	23
24	Travel and Seminar	0	0	282	0	0	0	0	0	0	0	0	282	24
25	Other Admin. Staff Transportation	0	0	1,985	0	0	0	0	0	0	0	0	1,985	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,987	0	0	0	0	0	0	0	0	2,987	26
27	Other (specify):*	0	0	27,585	0	0	0	0	0	0	0	0	27,585	27
28	TOTAL General Administration	(22,522)	(501,200)	135,247	0	0	0	0	0	0	0	0	(388,475)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,019)	(797,897)	177,732	0	0	0	0	0	0	0	0	(642,184)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				2320 S LAWNSDALE	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSLT	\$ 6,000	CAREPLUS MGMT INC		\$	(6,000)	1
2	V	10	NURSING DEPT CONSLTS	250,000	" "			(250,000)	2
3	V	17	MANAGEMENT FEES	219,600	" "			(219,600)	3
4	V	19	ADMIN CONSULTANT FEES	206,000	" "			(206,000)	4
5	V	19	DATA PROCESSING FEES	12,000	" "			(12,000)	5
6	V	21	CLERICAL FEES	63,600	" "			(63,600)	6
7	V	35	COMPUTER LEASE	8,333	" "			(8,333)	7
8	V	10a	THERAPY SERVICES	40,697	CAREPLUS REHABILITATIVE SERVICES			(40,697)	8
9	V	39	ANCILLARY SERVICES	131,422	" "			(131,422)	9
10	V								10
11	V	34	RENT	369,401	2320 S LAWNSDALE LLC			(369,401)	11
12	V	30	SL DEPRECIATION		" "		43,465	43,465	12
13	V	32	INTEREST		" "		270,062	270,062	13
14	Total			\$ 1,307,053			\$ 313,527	\$ * (993,526)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$	CAREPLUS MGMT INC	100.00%	\$ 5,679	\$ 5,679	15
16	V	5	ELECTRICITY		" "		291	291	16
17	V	6	MAINT & REPAIRS		" "		691	691	17
18	V	6	MAINTENANCE SALARIES		" "		7,136	7,136	18
19	V	10	NURSING SALARIES		" "		22,521	22,521	19
20	V	10a	THERAPY SUPPLIES/SVC		" "		200	200	20
21	V	10a	THERAPY SALARIES		" "		5,967	5,967	21
22	V	17	ADMIN SALARIES		" "		37,116	37,116	22
23	V	19	PROFESSIONAL FEES		" "		5,230	5,230	23
24	V	20	ADVERTISING		" "		1,732	1,732	24
25	V	21	OFFICE EXPENSE		" "		14,454	14,454	25
26	V	21	OFFICE SALARIES		" "		43,173	43,173	26
27	V	23	SEMINARS		" "		703	703	27
28	V	24	TRAVEL		" "		282	282	28
29	V	25	TRANSPORTATION		" "		1,985	1,985	29
30	V	26	INSURANCE		" "		2,987	2,987	30
31	V	27	EMPLOYEE BENEFITS		" "		27,585	27,585	31
32	V	30	DEPRECIATION		" "		9,386	9,386	32
33	V	32	INTEREST		" "		23,030	23,030	33
34	V	34	OFFICE RENT		" "		5,917	5,917	34
35	V	35	EQUIPMENT RENT		" "		5,482	5,482	35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 221,547	\$ * 221,547	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								\$		1
2	JACOB BAKST	DIR OPERATIONS	ADMIN,CONSULT		SEE ATTACHED			SALARY	10,988	17-7	2
3	SHERWIN I. RAY	PRESIDENT	ADMIN, FINANCE,		SCHEDULES			SALARY	10,988	17-7	3
4			BANKING								4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,976		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PARK HOUSE# 0034991 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CAREPLUS MANAGEMENT, INC
Street Address 5940 W TOUHY
City / State / Zip Code NILES, IL 60714
Phone Number (847) 647-1717
Fax Number (847) 647-0222

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	579,760	13	\$ 75,722	\$ 75,722	34,436	\$ 5,679	1
2	5	ELECTRICITY	" "	579,760	13	4,894		34,436	291	2
3	6	MAINT & REPAIRS	" "	579,760	13	11,630		34,436	691	3
4	6	MAINTENANCE SALARIES	" "	579,760	13	120,135	120,135	34,436	7,136	4
5	10	NURSING SALARIES	" "	579,760	13	379,168	379,168	34,436	22,521	5
6	10a	THERAPY SUPPLIES/SVC	" "	579,760	13	3,372		34,436	200	6
7	10a	THERAPY SALARIES	" "	579,760	13	100,459	100,459	34,436	5,967	7
8	17	ADMIN SALARIES	" "	579,760	13	624,886	624,886	34,436	37,116	8
9	19	PROFESSIONAL FEES	" "	579,760	13	88,050		34,436	5,230	9
10	20	ADVERTISING	" "	579,760	13	29,166		34,436	1,732	10
11	21	OFFICE EXPENSE	" "	579,760	13	243,348		34,436	14,454	11
12	21	OFFICE SALARIES	" "	579,760	13	726,859	726,859	34,436	43,173	12
13	23	SEMINARS	" "	579,760	13	11,834		34,436	703	13
14	24	TRAVEL	" "	579,760	13	4,741		34,436	282	14
15	25	TRANSPORTATION	" "	579,760	13	33,425		34,436	1,985	15
16	26	INSURANCE	" "	579,760	13	50,288		34,436	2,987	16
17	27	EMPLOYEE BENEFITS	" "	579,760	13	464,414		34,436	27,585	17
18	30	DEPRECIATION	" "	579,760	13	158,032		34,436	9,386	18
19	32	INTEREST	" "	579,760	13	387,734		34,436	23,030	19
20	34	OFFICE RENT	" "	579,760	13	99,626		34,436	5,917	20
21	35	EQUIPMENT RENT	" "	579,760	13	92,291		34,436	5,482	21
22										22
23										23
24										24
25	TOTALS					\$ 3,710,074	\$ 2,027,229		\$ 221,547	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	RELATED PARTY: 2320 S LAWNGDALE LLC						\$		\$			\$	1	
2	NOMURA		X	MORTGAGE	\$26,476.97	12/95		3,185,096	2,849,176	11/10/07	9.2500	256,010	2	
3													3	
4	CAREPLUS MANAGEMENT	X		CAPITAL IMPRV LOAN	\$4,739.35			225,000	149,352			14,052	4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related				\$31,216.32		\$	3,410,096	\$	2,998,528		\$	270,062	9
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$	14	
15	TOTALS (line 9+line14)						\$	3,410,096	\$	2,998,528		\$	270,062	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>			
1. Real Estate Tax accrual used on 2001 report.		\$ 72,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 72,924	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 424	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 74,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 74,824	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1997	62,474	8
1998	63,583	9
1999	63,156	10
2000	71,075	11
2001	72,924	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK HOUSE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034991

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 16-26-105-075-0000	NURSING HOME	\$ 31,529.00	\$ 31,529.00
2. 16-26-105-080-0000	NURSING HOME	\$ 20,736.00	\$ 20,736.00
3. 16-26-105-079-0000	NURSING HOME	\$ 20,659.00	\$ 20,659.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 72,924.00	\$ 72,924.00

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,000	1995	\$ 100,000	1
2					2
3	TOTALS	51,000		\$ 100,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5	106		1989		1,209,350	38,397	39	38,397		535,949	5
6											6
7											7
8						70		70			8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS		1989		17,739	563	20	887	324	11,772	9
10	LEASEHOLD IMPROVEMENTS		1989		4,204	280	15	280		3,850	10
11	LEASEHOLD IMPROVEMENTS		1990		11,700	371	20	585	214	7,209	11
12	LEASEHOLD IMPROVEMENTS		1991		17,413	553	20	871	318	10,016	12
13	LEASEHOLD IMPROVEMENTS		1992		55,138	1,858	31.5	1,750	(108)	18,696	13
14	LEASEHOLD IMPROVEMENTS		1993		26,399	748	31.5	838	90	7,961	14
15	LEASEHOLD IMPROVEMENTS		1994		3,400	87	39	87		765	15
16	ROOF REPAIR		1995		1,500	38	39	38		287	16
17	ROOF-TOP HEAT/A/C		1996		10,000	256	39	256		1,761	17
18	CEILING TILE / DUMBWAITER REPAIR		1996		12,253	314	39	314		2,081	18
19	RE-ROOF		1996		80,861	2,073	39	2,073		13,127	19
20	FIXTURES / WINDOWS		1996		3,850	99	39	99		613	20
21	WINDOWS		1997		18,900	483	39	483		2,585	21
22	ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION		1997		3,228	82	39	82		454	22
23	DOOR & FLOORING		1997		2,922	75	39	75		416	23
24	ELEVATOR REPAIR		1997		3,125	80	39	80		430	24
25	WINDOWS		1998		12,600	323	39	323		1,535	25
26	TILE AND FLOORING		1998		23,810	611	39	611		2,887	26
27	ELECTRICAL, PLUMBING, AND ELEVATOR REPAIR		1998		31,238	801	39	801		3,713	27
28	NEW NURSES STATIONS		1998		24,271	622	39	622		3,033	28
29	WINDOW TREATMENTS AND BRAILLE SIGNS		1998		3,478	89	39	89		419	29
30	FIRE SYSTEM UPGRADE AND DAMPERS		1998		8,833	225	39	225		982	30
31	REAR PARKING LOT REPAIRS		1998		10,550	704	15	704		3,167	31
32	WINDOWS / CLOSETS / OUTLETS / DUMBWAITER / ROOF		1999		23,174	594	39	594		2,203	32
33	ROOF REPAIR		1999		18,365	471	39	471		1,668	33
34	FRONT RAMP REPAIR		2000		1,200	44	27.5	44		74	34
35	VINYL TILE / KITCHEN		2000		6,213	226	27.5	226		556	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DUMBWAITER REPAIR	2001	\$ 3,264	\$ 119	27.5	\$ 119	\$	\$ 213	37
38	SIDEWALK / TUCKPOINTING	2001	5,500	367	15	367		550	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	138	27.5	138		155	39
40	BOILER	2002	5,229	87	27.5	87		87	40
41	AC UNITS	2002	6,365	106	27.5	106		106	41
42	FLOORING	2002	2,328	39	27.5	39		39	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,672,200	\$ 51,993		\$ 52,831	\$ 838	\$ 639,359	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$169,629	\$22,243	\$16,012	\$(6,231)	10	\$82,919	71
72	Current Year Purchases	18,874	8,305	944	(7,361)	10	944	72
73	Fully Depreciated Assets	83,390				10	83,390	73
74	RELATED PARTY		9,316	9,316				74
75	TOTALS	\$271,893	\$39,864	\$26,272	\$(13,592)		\$167,253	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,044,093	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$91,857	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$79,103	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(12,754)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$806,612	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 21,457 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		12		3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 77,409	\$		\$ 77,409	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			406			406	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			53,609			53,609	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				42,558		42,558	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Rentals/Lab/Med Supp	39-2 & 3					1,844		1,844	13
14	TOTAL			\$		\$ 131,424	\$ 44,402		\$ 175,826	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>55,000</u>)	1,616,053		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	789		6
7	Other Prepaid Expenses	4,087		7
8	Accounts Receivable (owners or related parties)	385,000		8
9	Other(specify): <u>RE ESCROW</u>	10,391		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,016,320	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	303,104		15
16	Equipment, at Historical Cost	271,893		16
17	Accumulated Depreciation (book methods)	(257,574)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>REPLACEMENT RESERVE</u>	43,621		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 361,044	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,377,364	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 328,796	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,239		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	6,162		31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 483,597	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,378		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,378	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 528,975	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,848,389	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,377,364	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,484,138	1
2	Restatements (describe):		2
3	BAD DEBTS	(25,000)	3
4	ILLINOIS REPLACEMENT TAX	(3,975)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,455,163	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	393,226	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 393,226	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,848,389	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **PARK HOUSE** # **0034991** Report Period Beginning: **01/01/2002** Ending: **12/31/2002**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,138,667	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,138,667	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,624	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,624	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33,576	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,576	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	717	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 717	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,174,584	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	641,677	31
32	Health Care	1,295,614	32
33	General Administration	1,105,518	33
	B. Capital Expense		
34	Ownership	504,688	34
	C. Ancillary Expense		
35	Special Cost Centers	175,826	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,781,358	40
41	Income before Income Taxes (line 30 minus line 40)**	393,226	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 393,226	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,349	2,516	\$ 53,581	\$ 21.30	1
2	Assistant Director of Nursing	1,677	1,853	31,291	16.89	2
3	Registered Nurses	3,892	4,160	122,186	29.37	3
4	Licensed Practical Nurses	10,093	10,382	197,877	19.06	4
5	Nurse Aides & Orderlies	43,237	47,090	412,217	8.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,963	4,224	50,961	12.06	8
9	Activity Director	1,524	1,700	18,164	10.68	9
10	Activity Assistants	3,876	4,096	35,551	8.68	10
11	Social Service Workers	1,809	1,977	22,670	11.47	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,181	29,919	13.72	13
14	Head Cook	4,435	4,837	43,864	9.07	14
15	Cook Helpers/Assistants	9,556	10,197	73,005	7.16	15
16	Dishwashers					16
17	Maintenance Workers	1,324	1,381	11,049	8.00	17
18	Housekeepers	13,452	14,750	114,608	7.77	18
19	Laundry	3,035	3,358	28,744	8.56	19
20	Administrator	1,297	1,498	52,299	34.91	20
21	Assistant Administrator	2,404	2,726	51,790	19.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,537	7,140	88,214	12.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	771	816	7,142	8.75	31
32	Other Health Care(specify) _____					32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	117,240	126,882	\$ 1,445,132 *	\$ 11.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 6,000	1-3	35
36	Medical Director	O	2,500	9-3	36
37	Medical Records Consultant	N	51,760	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	750	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,057	11-3	44
45	Social Service Consultant	E	3,735	12-3	45
46	Other(specify) _____	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 77,602		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
EUGENE BERGER	ADMIN	0	\$ 52,299	Workers' Compensation Insurance	\$	39,070	IDPH License Fee	\$
DENISE WILLIAMS	ASST ADMIN	0	51,790	Unemployment Compensation Insurance		13,696	Advertising: Employee Recruitment	15,763
				FICA Taxes		109,541	Health Care Worker Background Check	0
				Employee Health Insurance		57,988	(Indicate # of checks performed)	
				Employee Meals		11,717	MARKETING/ADV/PROMO	6,810
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	400
				EMPLOYEE BENEFITS - OTHER		1,894	LICENSES & PERMITS	2,554
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	7,263
				PENSION/PROFIT SHARING PLANS		12,084	MGMT CO ALLOCATION	1,732
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		3,600	TRUST/FRANCHISE/CONTRIB/ETC	(400)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(2,777)
							Yellow page advertising	(4,033)
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	249,590	TOTAL (agree to Sch. V,	\$ 27,312
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
AMERICAN DATA	DATA PROCESSING		\$ 2,685				Out-of-State Travel	\$
NATIONAL DATACARE	DATA PROCESSING		1,877					
CAREPLUS MGMT	DATA PROCESSING		12,000					
ECONOCARE	PURCHASING CONSULT		2,520				In-State Travel	
PERSONNEL PLANNER	UNEMPLOYMENT CONS		1,294					0
KBKB LTD	ACCOUNTING		27,750				MGMT CO ALLOCATION	282
RICHARD PEELO	MEDICARE CONSULTNT		3,750					
MEYER MAGENCE	LEGAL		4,031				Seminar Expense	
ART ROUSEAU	LEGAL		150					0
CORP LINK SERVICES	LEGAL		574					
CAREPLUS MGMT	ADMINISTRATIVE CONS		206,000					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)							line 24, col. 8)	\$ 282
			\$ 262,631					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATING	2000	\$ 2,797		\$	\$ 467	\$ 932	\$ 932	\$ 466	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,797		\$	\$ 467	\$ 932	\$ 932	\$ 466	\$	\$	\$	\$

Facility Name & ID Number **PARK HOUSE**# **0034991**Report Period Beginning: **01/01/2002** Ending: **12/31/2002****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNC LONG TERM CARE \$5774
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 493 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 58,035
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 11,717 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,000
	REPAIRS & MAINTENANCE	6,969
		0
		12,969
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	24,888
	ELECTRICITY	30,065
	WATER	11,551
	CABLE TV - LOBBY	732
		0
		67,236
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,364
	PAINTING & DECORATING	1,334
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	5,166
	ELEVATOR MAINTENANCE & REPAIR	8,540
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,600
	FIRE SERVICE	4,777
		0
		0
		0
		25,781
7	OTHER	
	SCAVENGER	12,065
	SECURITY SERVICE	0
		12,065
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	2,500
		2,500

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	53
	DENTAL SERVICES	1,000
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	51,760
	PHARMACY CONSULTANT XVIII B 39-2	750
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PROGRAM CONSULTANT XVIII B __-2	100,000
	PSYCHIATRIC XVIII B __-2	100,000
	RN CONSULTANT XVIII B 38-2	
		0
		0
		253,563
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	9,707
	SPEECH THERAPY SERVICES	176
	OCCUPATIONAL THERAPY SERVICES	7,160
	THERAPY CONTRACT SERVICES	12,855
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		40,698
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,057
		0
		2,057
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,735
		0
		3,735
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES			PAGE 3 COLUMN 3 OTHER	
LINE	SCHED REF	TOTAL		
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION	586	586	
17	ADMINISTRATIVE			
	MANAGEMENT FEES XIX B	219,600	219,600	
18	DIRECTORS FEES	0	0	
19	PROFESSIONAL SERVICES			
	DATA PROCESSING XIX C	16,562		
	ADMINISTRATIVE CONSULTANTS XIX C	206,000		
	PROFESSIONAL FEES XIX C	40,069		
		0	262,631	
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT & MARKETING VI 19 XIX F	0		
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,746		
	EMPLOYEE WANT ADS XIX F	15,763		
	CONTRIBUTIONS VI 20 XIX F	400		
	DUES & SUBSCRIPTIONS XIX F	7,263		
	LICENSES & PERMITS XIX F	2,554		
	PUBLIC RELATIONS-PATIENT RELATED XIX F	31		
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,033		
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0		
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0		
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0	32,790	
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0		
	EQUIPMENT REPAIR & MAINTENANCE	8,140		
	OUTSIDE CLERICAL SERVICES	63,600		
	PENALTIES VI 18	15,312		
	HOME OFFICE EXPENSE	0		
	THEFT & DAMAGE LOSS	0		
	TELEPHONE	15,163		
	MESSENGER SERVICE	467		
		0	102,682	

LINE	SCHED REF	TOTAL		
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES XIX D	109,541		
	UNEMPLOYMENT COMPENSATION XIX D	13,696		
	WORKERS COMPENSATION INSURANC XIX D	39,070		
	HOSPITALIZATION INSURANCE XIX D	57,988		
	EMPLOYEE BENEFITS - OTHER XIX D	1,894		
	EMPLOYEE PHYSICAL EXAMS XIX D	0		
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0		
	PENSION/PROFIT SHARING PLANS XIX D	12,084		
	CHICAGO HEAD TAX XIX D	3,600	237,873	
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS	1,165	1,165	
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS XIX G	0		
	TRAVEL XIX G	0		
		0		
		0	0	
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF	1,615	1,615	
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE	38,048	38,048	
27	OTHER			
	BAD DEBTS VI 24	0		
		0	0	

GRAND TOTAL COLUMN 3 OTHER

1,317,594

PARK HOUSE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	122,338	PATIENT MEALS	103308
LESS SALES TAX	(429)	ADD EMPLOYEE MEALS	10950
	-----		-----
NET FOOD	121,909	TOTAL MEALS/YEAR	114258
TOTAL PATIENT CENSUS	34,436	NET FOOD	121909
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	114258

TOTAL PATIENT MEALS	103308	COST PER MEAL	1.07
		TIME EMPLOYEE MEALS	10950
ADD # EMPLOYEE MEALS/DAY	30		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	11717
	-----		=====
TOTAL EMPLOYEE MEALS	10950		